Appendix 8
Prior Authorization Chiropractic Attachment (PA/CA) Sample

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/CA

PRIOR AUTHORIZATION CHIROPRACTIC ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Ima	A	1234567890	29

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
IM Performing	12345678	(XXX) XXX - XXXX

Requesting prior authorization to extend treatment beyond twenty (20) Manipulations per spell of illness

1. Requesting 12 manipulations per month, over 6 months.

2. Recipient's history:

4. Objective findings:

When Ima was last seen on MMDDYY, she had tenderness over the L-S area, and muscle tightness for the quadratus laborum and over the right scaphoid region.

5. Recipient's subjective and objective progress:

Ima is able to go approximately two weeks before requiring a treatment. Immediately after treatment, there is a release of the muscle spasticity and associated pain.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

MMDDYY
Date

J. M. Provider
Requesting Provider's Signature